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## **TITLE 9. HEALTH SERVICES**

### **CHAPTER 11. DEPARTMENT OF HEALTH SERVICES**

#### **HEALTH CARE INSTITUTIONS: RATES AND CHARGES INSTITUTION FACILITY DATA**

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## **ARTICLE 1. GENERAL DEFINITIONS**

### **R9-11-101. Definitions**

- A.** ~~“Accrual” means recording revenues and expenses when incurred with specific periods of time, such as a month or year, without regard to the date of receipt or payment of cash.~~
- B.** ~~“Affiliated Organization” means the same as “related party.”~~
- C.** ~~“Annualized” means data for any period adjusted to represent a 12-month time period.~~
- D.** ~~“Charge Code” means a numeric or alpha-numeric identifier assigned by the health care institution to a unit of service such as a procedure, test, or commodity for which a separate charge is levied to a patient and used for identification on a patient’s itemized bill.~~
- E.** ~~“Charity Allowances” means reductions in charges for services made by the health care institution because of the indigence of the patient. This does not include Title XIX Arizona Health Care Cost Containment Service (AHCCCS) or any other third-party payor settlements.~~
- F.** ~~“Department” or “DHS” means the Department of Health Services.~~
- G.** ~~“Direct costs” means those costs which are incurred by and charged directly to the revenue-producing departments of the institution.~~
- H.** ~~“Director” means the Director of the Department.~~
- I.** ~~“Durable Medical Equipment” means reusable equipment a health care institution makes available for patient services. The equipment can be sold, rented or furnished at no cost to a patient.~~
- J.** ~~“Expendable” means those non-reusable commodities that may be sold to and are consumed by the patient.~~
- K.** ~~“Formula” means a defined mathematical progression applied to the cost of a product to calculate a patient charge.~~
- L.** ~~“Health care institution” or “institution” means every place, building or agency, whether organized for profit or not, which provides medical services, nursing services, or health-related services, except those institutions exempted by A.R.S. 36-402.~~
- M.** ~~“Indirect costs” means those costs which are incurred by and charged directly to the non-revenue-producing departments and then are proportionately allocated to the revenue-producing departments of the institution.~~
- N.** ~~“Inpatient hospice” means a hospice licensed by the Department pursuant to A.R.S. 36-405, 36-422 and A.A.C. Title 9, Chapter 10, Article 8 providing 24-hour inpatient care.~~
- O.** ~~“Level of Care” means categorizing patient services according to the type of care provided by the health care institution. Patient care factors, such as nursing hours, physical assistance or~~

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- ~~administration of medications, may be assigned numeric values generating accumulated or weighted points used to apply charges.~~
- P.** ~~“Managed Care” means services delivered to clients through a health maintenance organization, preferred provider organization, third party administrator or an independent physician association.~~
- Q.** ~~“Material” means a significant change in revenue or expense in relation to total revenue or significant changes that affect how a facility is managed or controlled.~~
- R.** ~~“Natural Classification” means the classification of expenses as reported on the income statement; i.e., the nature of the items as accrued, such as, salaries/wages, benefits, supplies, purchased services, insurance, and depreciation.~~
- S.** ~~“Nonexpendable” means those reusable items that may be rented or sold to the patient. This may include durable medical equipment.~~
- T.** ~~“Pass through” means any outside service or purchased commodity that is charged to a patient at the health care institution’s cost.~~
- U.** ~~“Private payor” means an individual or insurance company responsible for the payment of services. Third party government payor programs are not considered private payors.~~
- V.** ~~“Rate or Charge” means a separate dollar amount levied to a patient for use or consumption of a unit of service or commodity.~~
- W.** ~~“Related Party” means an investor (individual, partner or corporation) having more than 5% ownership of another entity.~~
- X.** ~~“Senior Plan” means contracted managed care services that are an alternate method of delivering services to Medicare eligible clients.~~
- Y.** ~~“Service” means a unit of care such as a procedure, test, or commodity for which a separate rate or charge is made to a patient.~~

In this Chapter, unless otherwise specified:

1. “Admission” or “admitted” means documented acceptance by a health care institution of an individual as an inpatient of a hospital, a resident of a nursing care institution, or a patient of a hospice.
2. “AHCCCS” means the Arizona Health Care Cost Containment System, established under A.R.S. § 36-2902.
3. “Allowance” means a charity care discount, self-pay discount, or contractual adjustment.
4. “Arizona facility ID” means a unique code assigned to a hospital by the Department to identify the source of inpatient discharge or emergency department discharge information.

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5. “Attending provider” means the medical practitioner who has primary responsibility for the services a patient receives during an episode of care.
6. “Available bed” means an inpatient bed or resident bed, as defined in A.R.S. § 36-401, for which a hospital, nursing care institution, or hospice has health professionals and commodities to provide services to a patient or resident.
7. “Bill” means a statement for money owed to a health care institution for the provision of the health care institution’s services.
8. “Business day” means any day of the week other than a Saturday, a Sunday, a legal holiday, or a day on which the Department is authorized or obligated by law or executive order to close.
9. “Calendar day” means any day of the week, including a Saturday or a Sunday.
10. “Cardiopulmonary resuscitation” means the same as in A.R.S. § 36-3251.
11. “Charge” means a specific dollar amount set by a health care institution for the use or consumption of a unit of service provided by the health care institution.
12. “Charge source” means the unit within a health care institution that provided services to an individual for which the individual’s payer source is billed.
13. “Charity care” means services provided without charge to an individual who meets certain financial criteria established by a health care institution.
14. “Chief administrative officer” means the same as in A.A.C. R9-10-101.
15. “Chief financial officer” means an individual who is responsible for the financial records of a health care institution.
16. “Classification” means a designation that indicates the types of services a hospital provides.
17. “Clinical evaluation” means an examination performed by a medical practitioner on the body of an individual for the presence of disease or injury to the body, and review of any laboratory test results for the individual.
18. “Commodity” means a non-reusable material, such as a syringe, bandage, or IV bag, utilized by a patient or resident.
19. “Contractual adjustment” means the difference between charges billed to a payer source and the amount that is paid to a health care institution based on an established agreement between the health care institution and the payer source.
20. “Control number” means a unique number assigned by a hospital for an individual’s specific episode of care.

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- 21. “Code” means a single number or letter, a set of numbers or letters, or a combination of numbers and letters that represents specific information.
- 22. “Department” means the Arizona Department of Health Services.
- 23. “Designee” means a person assigned by the governing authority of a health care institution or by an individual acting on behalf of the governing authority to gather information for or report information to the Department.
- 24. “Diagnosis” means the identification of a disease or injury, by an individual authorized by law to make the identification, that is a cause of an individual’s current medical condition.
- 25. “Discharge” means a health care institution’s termination of services to a patient or resident for a specific episode of care.
- 26. “Discharge status” means the disposition of a patient, including whether the patient was:
  - a. Discharged home,
  - b. Transferred to another health care institution, or
  - c. Died.
- 27. “DNR” means Do Not Resuscitate, a document prepared for a patient indicating that cardiopulmonary resuscitation is not to be used in the event that the patient’s heart stops beating.
- 28. “E-code” means an International Classification of Diseases code that is used:
  - a. In conjunction with other International Classification of Diseases codes that identify the principal and secondary diagnoses for an individual; and
  - b. To further designate the individual’s injury or illness as being caused by events such as:
    - i. An external cause of injury, such as a car accident;
    - ii. A poisoning; or
    - iii. An unexpected complication associated with treatment, such as an adverse reaction to a medication or a surgical error.
- 29. “Electronic” means the same as in A.R.S. § 36-301.
- 30. “Emergency” means the same as in A.A.C. R9-10-201.
- 31. “Emergency department” means the unit within a hospital that is designed for the provision of emergency services.
- 32. “Emergency services” means the same as in A.A.C. R9-10-201.
- 33. “Episode of care” means medical services, nursing services, or health-related services provided by a hospital to a patient for a specific period of time, ending with a discharge.

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- 34. "Fiscal year" means a consecutive 12-month period established by a health care institution for accounting, planning, or tax purposes.
- 35. "Governing authority" means the same as in A.R.S. § 36-401.
- 36. "Health care institution" means the same as in A.R.S. § 36-401.
- 37. "Health-related services" means the same as in A.R.S. § 36-401.
- 38. "Home health agency" means the same as in A.R.S. § 36-151.
- 39. "Home health services" means the same as in A.R.S. § 36-151.
- 40. "Home office" means the person that is the owner of and controls the functioning of a nursing care institution.
- 41. "Hospice" means the same as in A.R.S. § 36-401.
- 42. "Hospital" means the same as in A.A.C. R9-10-201.
- 43. "Hospital administrator" means the same as "administrator" in A.A.C. R9-10-201.
- 44. "Hospital services" means the same as in A.A.C. R9-10-201.
- 45. "International Classification of Diseases Code" means a code included in a set of codes such as the ICD-9-CM or ICD-10-CM codes, which is used by a hospital for billing purposes.
- 46. "Inpatient" means the same as in A.A.C. R9-10-201.
- 47. "Licensed capacity" means the same as in A.R.S. § 36-401.
- 48. "Management company" means an entity that:
  - a. Acts as an intermediary between the governing authority of a nursing care institution and the individuals who work in the nursing care institution.
  - b. Takes direction from the governing authority of the nursing care institution, and
  - c. Ensures that the directives of the governing authority of the nursing care institution are carried out.
- 49. "Medical practitioner" means an individual who is:
  - a. Licensed:
    - i. As a physician;
    - ii. As a dentist, under A.R.S. Title 32, Chapter 11, Article 2;
    - iii. As a podiatrist, under A.R.S. Title 32, Chapter 7;
    - iv. As a registered nurse practitioner, under A.R.S. Title 32, Chapter 15;
    - v. As a physician assistant, under A.R.S. Title 32, Chapter 25; or
    - vi. To use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state; or

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- b. Licensed in another state and authorized by law to use or prescribe drugs or devices for the evaluation, diagnosis, prevention, or treatment of illness, disease, or injury in human beings in this state.
- 50. "Medical record number" means a unique number assigned by a hospital to an individual for identification purposes.
- 51. "Medical services" means the same as in A.R.S. § 36-401.
- 52. "Medicare" means a federal health insurance program established under Title XVIII of the Social Security Act.
- 53. "National provider identifier" means the unique number assigned by the Centers for Medicare and Medicaid Services to a health care institution, physician, registered nurse practitioner, or other medical practitioner to submit claims and transmit electronic health information to all payer sources.
- 54. "Newborn" means a human:
  - a. Whose birth took place in the reporting hospital, or
  - b. Who was:
    - i. Born outside a hospital,
    - ii. Admitted to the reporting hospital within 24 hours of birth, and
    - iii. Admitted to the reporting hospital before being admitted to any other hospital.
- 55. "Nursing care institution" means the same as in A.R.S. § 36-446.
- 56. "Nursing care institution administrator" means the same as in A.R.S. § 36-446.
- 57. "Nursing services" means the same as in A.R.S. § 36-401.
- 58. "Patient" means the same as in A.A.C. R9-10-101.
- 59. "Payer source" means an individual or an entity, such as a private insurance company, AHCCCS, or Medicare, to which a health care institution sends a bill for the services provided to an individual by the health care institution.
- 60. "Physician" means an individual licensed as a doctor of allopathic medicine under A.R.S. Title 32, Chapter 13, as a doctor of naturopathic medicine under A.R.S. Title 32, Chapter 14, or as a doctor of osteopathic medicine under A.R.S. Title 32, Chapter 17.
- 61. "Principal diagnosis" means the reason established after a clinical evaluation of a patient to be chiefly responsible for a specific episode of care.
- 62. "Principal procedure" means the procedure judged by an individual working on behalf of a hospital to be:
  - a. The most significant procedure performed during an episode of care, or

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- b. The procedure most closely associated with a patient's principal diagnosis.
- 63. "Priority of visit" means the urgency with which a patient required medical services during an episode of care.
- 64. "Procedure" means a set of activities performed on a patient that:
  - a. Is intended to diagnose or treat a disease, illness, or injury;
  - b. Requires the individual performing the set of activities be trained in the set of activities; and
  - c. May be invasive in nature or involve a risk to the patient from the activities themselves or from anesthesia.
- 65. "Prospective payment system" means a system of classifying episodes of care for billing and reimbursement purposes, based on factors such as diagnoses, age, and sex.
- 66. "Refer" means to direct an individual to a health care institution for services provided by the health care institution.
- 67. "Referral source" means a code designating the entity that referred or transferred a patient to a hospital.
- 68. "Registered nurse practitioner" means an individual who meets the definition of registered nurse practitioner in A.R.S. § 32-1601, and is licensed under A.R.S. Title 32, Chapter 15.
- 69. "Reporting period" means the specific fiscal year, calendar year, or portion of the fiscal or calendar year for which a health care institution is reporting data to the Department.
- 70. "Residence" means the place where an individual lives, such as:
  - a. A private home,
  - b. A nursing care institution, or
  - c. An assisted living facility.
- 71. "Resident" means the same as in:
  - a. A.A.C. R9-10-701, or
  - b. A.A.C. R9-10-901.
- 72. "Revenue code" means a code for a unit of service that a hospital includes on a bill for hospital services.
- 73. "Secondary diagnosis" means any diagnosis for an individual other than the principal diagnosis.
- 74. "Self-pay discount" means a reduction in charges billed to an individual.

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- 75. “Service” means an activity performed as part of medical services, hospital services, nursing services, emergency services, health-related services, hospice services, home health services, or supportive services.
- 76. “Supportive services” means the same as in A.R.S. § 36-151.
- 77. “Transfer” means discharging an individual from a health care institution so the individual may be admitted to another health care institution.
- 78. “Trauma center” means the same as in:
  - a. A.R.S. § 36-2201, or
  - b. A.R.S. § 36-2225.
- 79. “Treatment” means the same as in R9-10-101.
- 80. “Type of” means a specific subcategory of the following that is provided, enumerated, or utilized by a health care institution:
  - a. An employee or contracted worker;
  - b. An accounting concept, such as asset, liability, or revenue;
  - c. A non-covered ancillary charge;
  - d. A payer source;
  - e. A charge source;
  - f. A medical condition; or
  - g. A service.
- 81. “Type of bed” means a category of available bed that specifies the services provided to an individual occupying the available bed.
- 82. “Unit” means an area within a health care institution that is designated by the health care institution to provide a specific type of service.
- 83. “Unit of service” means a procedure, service, commodity, or other item or group of items provided to a patient or resident for which a health care institution bills a payer source a specific amount.
- 84. “Written notice” means a document that is provided:
  - a. In person,
  - b. By delivery service,
  - c. By facsimile transmission,
  - d. By electronic mail, or
  - e. By mail.

## **ARTICLE 2. ~~UNIFORM ACCOUNTING SYSTEM~~**

### **ANNUAL FINANCIAL STATEMENTS AND UNIFORM ACCOUNTING REPORTS**

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**R9-11-201. Annual Filing of Operating Statements and Reports Definitions**

**A.** ~~Every hospital, nursing care institution and inpatient hospice shall submit to the Director not later than 120 days following the institution's fiscal year end the following statements and reports for the reporting year:~~

- ~~1. Hospitals shall file:
  - a. A report of an audit by an independent certified public accountant conducted in accordance with generally accepted auditing standards in the format defined in A.R.S. § 36-125.04(B).
  - b. A copy of the hospital's annual Medicare Cost Report.
  - c. A copy of the uniform accounting report pursuant to R9-11-202.~~
- ~~2. Nursing care institutions (NCI) shall submit a completed Arizona Reporting System for Nursing Institutional Costs (ARSNIC) forms set as their uniform accounting report, and a copy of the annual Medicare Cost Report. The ARSNIC report shall be submitted to the Department in electronic and paper copy format.~~
- ~~3. Inpatient Hospice: Revenue, patient statistics, and expenses related to operating an inpatient hospice shall be delineated either in the Medicare Cost Report for Hospitals or ARSNIC for Nursing Care Institutions.~~

**B.** ~~The Director may grant a 30-day extension in writing in advance of the due date of any required reports. The health care facility shall request such extension in writing at least 30 days prior to the due date pursuant to A.R.S. § 36-125.04. The request for extension of time shall include the following:~~

- ~~1. Name and address of the facility,~~
- ~~2. Reason for the request,~~
- ~~3. Requested due date,~~
- ~~4. Name(s) of the operating statements or reports for which an extension is being requested.~~

In this Article, unless otherwise specified:

1. "Accredited" means the same as in A.R.S. § 36-422.
2. "ALTCS" means the Arizona Long-term Care System established under A.R.S. § 36-2932.
3. "Asset" means the same as "asset" in generally accepted accounting principles.
4. "Audit" means the same as "audit" in generally accepted accounting principles.
5. "Bereavement services" means activities provided by or on behalf of a hospice to the family or friends of an individual that are intended to comfort the family or friends before and after the individual's death.

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6. “Building improvement” means an addition to or reconstruction, removal, or replacement of any portion or component of an existing building that affects licensed capacity, increases the useful life of an available bed, or enhances resident safety.
7. “Caseload” means the number of assigned patients for which an individual working for a hospice is to provide hospice services.
8. “Certified nursing assistant” means the same as “nursing assistant” in A.R.S. § 32-1601.
9. “Chaplain” means an individual trained to offer support, prayer, and spiritual guidance to a patient and the patient’s family.
10. “Continuous care” means hospice services provided in a patient’s residence to a patient who requires nursing services to be available 24 hours a day.
11. “Contracted worker” means an individual who:
  - a. Performs:
    - i. Hospital services in a hospital,
    - ii. Nursing services or health-related services in a nursing care institution,
    - iii. Hospice services for a hospice, or
    - iv. Labor as a medical record coder or transcriptionist for a hospital; and
  - b. Is paid by a person with whom the hospital, nursing care institution, or hospice has a written agreement to provide hospital services, nursing services, health-related services, hospice services, or medical record coder or transcriptionist labor.
12. “Covered services” means hospice services that are provided to an individual by a hospice and are paid for by a payer source.
13. “Daily census” means a count of the number of patients to whom hospice services were provided during a 24-hour period.
14. “Direct care” means services provided to a resident that require hands-on contact with the resident.
15. “Direction” means the same as in A.R.S. § 36-401.
16. “Employee” means an individual other than a contracted worker who works for a health care institution for compensation and provides or assists in the provision of a service to patients or residents.
17. “Employee-related expenses” means costs incurred by an employer to pay for the employer’s portion of Social Security taxes, Medicare taxes, and other costs such as health insurance.
18. “Equity” means the same as “equity” in generally accepted accounting principles.

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19. "Expense" means the same as "expense" in generally accepted accounting principles.
20. "Free-standing" means that a health care institution is not located within another health care institution.
21. "FTE" means full-time equivalent position, which is a job for which a health care institution expects to pay an individual for 2,080 hours per year.
22. "Generally accepted accounting principles" means the set of financial reporting standards administered by the Financial Accounting Standards Board or the Governmental Accounting Standards Board.
23. "Health professional" means the same as in A.R.S. § 32-3201.
24. "Home health agency-based hospice" means a hospice that operates as part of a home health agency.
25. "Hospice administrator" means the chief administrative officer for a hospice.
26. "Hospice chief financial officer" means an individual who is responsible for the financial records of a hospice.
27. "Hospice inpatient facility" means the same as in A.A.C. R9-10-801.
28. "Hospice service" means the same as in A.A.C. R9-10-801.
29. "Hospice service agency" means the same as in A.R.S. § 36-401.
30. "Hospital-based hospice" means a hospice that is located within a hospital.
31. "Inpatient services" means the same as in A.A.C. R9-10-801.
32. "Inpatient surgery" means surgery that requires a patient to receive inpatient services in a hospital.
33. "Level of care" means a designation that indicates the scope of medical services, nursing services, and health-related services that are provided to a patient or resident.
34. "Liability" means the same as "liability" in generally accepted accounting principles.
35. "Licensed nurse" means a registered nurse practitioner, registered nurse, or practical nurse.
36. "Licensee" means the same as in R9-10-101.
37. "Median length of stay" means the midpoint in the number of patient care days for all patients who were discharged from a hospice during a specific period of time.
38. "Medicaid" means a federal health insurance program, administered by states, for individuals who meet specific income criteria established, in Arizona, by AHCCCS.
39. "Medical record coder" means an individual who assigns codes to a patient's diagnoses and procedures for billing purposes.

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- 40. “Medical record transcriptionist” means an individual who copies and edits dictation from medical practitioners into medical records.
- 41. “Medical records” mean the same as in A.R.S. § 12-2291.
- 42. “Medicare cost report” means the annual financial and statistical documents submitted to the United States Department of Health and Human Services as required by Title XVIII of the Social Security Act.
- 43. “Medicare-certified” means that a health care institution is authorized by the United States Department of Health and Human Services to bill Medicare for services provided to patients or residents who are eligible to receive Medicare.
- 44. “Midnight census” means a count of the number of patients or residents in a health care institution at 12:00 a.m.
- 45. “Net assets” means the same as “net assets” in generally accepted accounting principles.
- 46. “Non-covered ancillary services” means activities, such as rehabilitation services, laboratory tests, or x-rays, provided to an individual in a health care institution that are paid for by:
  - a. A payer source other than ALTCS, or
  - b. ALTCS to an entity that is not a health care institution.
- 47. “Nursery patient” means a newborn who was born in a hospital and not admitted to a type of bed that is counted toward the hospital’s licensed capacity.
- 48. “Nursing care institution-based hospice” means a hospice that is located within a nursing care institution.
- 49. “Nursing personnel” means the individuals authorized by a health care institution to provide nursing services to a patient or resident.
- 50. “Occupancy rate” means the midnight census divided by the number of available beds, expressed as a percent.
- 51. “Operating expense” means the same as “operating expense” in generally accepted accounting principles.
- 52. “Outpatient hospice services” means hospice services provided at a location outside a hospice inpatient facility.
- 53. “Outpatient surgery” means surgery that does not require a patient to receive inpatient services in a hospital.
- 54. “Owner” means the same as in A.A.C. R9-10-101.
- 55. “Patient care day” means a calendar day during which a hospice provides hospice services to a patient.

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- 56. “Patient day” means a period during which a patient received inpatient services with:

  - a. The time between the midnight census on two successive calendar days counting as one period, and
  - b. The day of discharge being counted only when the patient is admitted and discharged on the same day.
- 57. “Person” means the same as in A.R.S. § 41-1001.
- 58. “Practical nurse” means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice practical nursing, as defined in A.R.S. § 32-1601.
- 59. “Registered nurse” means an individual licensed under A.R.S. Title 32, Chapter 15, Article 2, to practice professional nursing, as defined in A.R.S. § 32-1601.
- 60. “Rehabilitation services” means the same as in A.A.C. R9-10-201.
- 61. “Resident day” means a period during which a resident received nursing services or health-related services provided by a nursing care institution with:

  - a. The time between the midnight census on two successive calendar days counting as one period, and
  - b. The day of discharge being counted only when the resident is admitted and discharged on the same day.
- 62. “Respite care services” means the same as in A.R.S. § 36-401.
- 63. “Revenue” means the same as “revenue” in generally accepted accounting principles.
- 64. “Routine home care” means hospice services provided in a patient’s residence to a patient who does not require nursing services to be available 24 hours a day.
- 65. “Rural” means the same as in A.R.S. § 36-2171.
- 66. “Self-pay” means that charges for hospice services are billed to an individual.
- 67. “Social worker” means an individual licensed according to A.R.S. §§ 32-3291, 32-3292, or 32-3293.
- 68. “Statement of cash flows” means the same as “statement of cash flows” in generally accepted accounting principles.
- 69. “Surgery” means the excision of a part of a patient’s body or the incision into a patient’s body for the correction of a deformity or defect; repair of an injury; or diagnosis, amelioration, or cure of disease.
- 70. “Turnover rate” means:

  - a. For a hospital, a percent calculated by dividing the number of individuals employed by the hospital who resign or retire from or are dismissed by the

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hospital during a reporting period by the average number of individuals employed during the reporting period; or

- b. For a nursing care institution, a percent calculated by dividing the number of employees who resign or retire from or are dismissed by a nursing care institution during a reporting period by the average number of employees during the reporting period.

71. “Uniform accounting report” means a document that meets the requirements of A.R.S. § 36-125.04 and contains the information required in R9-11-203 for hospitals, R9-11-204 for nursing care institutions, and R9-11-205 for hospices.

72. “Unscheduled medical services” means the same as in A.R.S. § 36-401.

73. “Urban” means an area not defined as “rural.”

74. “Urgent care unit” means a facility under a hospital’s license that is:

- a. Located within one-half mile of the hospital, and
- b. Designated by the hospital for the provision of unscheduled medical services for medical conditions that are of a less critical nature than emergency medical conditions.

75. “Vacancy rate” means a percent calculated by dividing the number of unfilled FTEs at the end of a hospital’s reporting period by the sum of the unfilled FTEs and filled FTEs at the end of the hospital’s reporting period.

76. “Volunteer” means the same as in A.A.C. R9-10-801.

**R9-11-205. Reserved Hospice Uniform Accounting Report**

**A.** A hospice administrator or designee shall submit a uniform accounting report to the Department, in a format specified by the Department, within 150 calendar days after the end of the hospice’s fiscal year.

**B.** A hospice administrator or designee shall submit a copy of the hospice’s Medicare and Medicaid cost reports, if applicable, as part of the uniform accounting report required in subsection (A).

**C.** The uniform accounting report required in subsection (A) shall include the following information:

- 1. The name, physical address, mailing address, county, and telephone number of the hospice;
- 2. The identification number assigned to the hospice:
  - a. By the Department;
  - b. By AHCCCS;
  - c. By Medicare, if applicable; and
  - d. As the hospice’s national provider identifier;

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3. The beginning and ending dates of the hospice's reporting period;
4. If the hospice began operations during the hospice's reporting period, the date on which the hospice began operations;
5. The name, telephone number, and e-mail address of the:
  - a. Hospice administrator,
  - b. Hospice chief financial officer, and
  - c. Individual who prepared the uniform accounting report;
6. The date the uniform accounting report was submitted to the Department;
7. Whether the hospice operates as a hospice service agency or a hospice inpatient facility;
8. Whether the entity that is the owner of the hospice is:
  - a. Not for profit;
  - b. For profit; or
  - c. A federal, state, or local government agency;
9. Whether or not the hospice is Medicare-certified;
10. The entity by which the hospice is accredited, if applicable;
11. Whether the hospice provides hospice services in an area that:
  - a. Is equal to or more than two-thirds urban,
  - b. Is equal to or more than two-thirds rural, or
  - c. Is less than two-thirds urban and less than two-thirds rural;
12. If the hospice operates as a hospice service agency, whether the hospice is:
  - a. Free-standing, or
  - b. A home health agency-based hospice;
13. If the hospice operates as a hospice inpatient facility:
  - a. Whether the hospice is:
    - i. Free-standing,
    - ii. A hospital-based hospice, or
    - iii. A nursing care institution-based hospice;
  - b. The levels of care provided;
  - c. The licensed capacity of the hospice;
  - d. The number of available beds at each level of care;
  - e. The total number of available beds at the beginning and end of the reporting period; and
  - f. The average occupancy rate at each level of care for the reporting period;
14. The number of patients during the reporting period that were:

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- a. Referred to the hospice,
  - b. Admitted to the hospice,
  - c. Died while admitted to the hospice, and
  - d. Discharged from the hospice while living;
- 15. The number of patient care days, for all patients, during the reporting period in which the hospice provided:
  - a. Routine home care,
  - b. Respite care services,
  - c. Continuous care, and
  - d. Inpatient services;
- 16. The total number of patient care days during the reporting period for all patients;
- 17. The average daily census for the reporting period, calculated as the number specified in subsection (C)(16) divided by the number of days in the reporting period;
- 18. Average length of stay, calculated as the number of patient care days for patients discharged during the reporting period divided by the sum of the numbers specified in subsections (C)(14)(c) and (C)(14)(d);
- 19. Median length of stay for patients discharged during the reporting period;
- 20. The number of patients admitted to the hospice during the reporting period:
  - a. By gender;
  - b. By age group;
  - c. By race and ethnicity;
  - d. From:
    - i. A private home owned or leased by, or on behalf of, a patient;
    - ii. An assisted living facility;
    - iii. A nursing care institution;
    - iv. A hospital;
    - v. A hospital-based or nursing care institution-based hospice;
    - vi. A free-standing hospice; and
    - vii. A private home owned by a hospice that only provides routine home care to patients;
  - e. With a principal diagnosis of:
    - i. Cancer,
    - ii. Heart disease,
    - iii. Dementia,

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- iv. Lung disease,
    - v. Kidney disease,
    - vi. Stroke or coma,
    - vii. Liver disease,
    - viii. HIV-related disease,
    - ix. Motorneuron disorder,
    - x. Unspecified debility, and
    - xi. A disease not specified in subsections (C)(20)(e)(i) through (C)(20)(e)(x); and
  - f. Whose payer source is:
    - i. Medicare,
    - ii. AHCCCS,
    - iii. Self-pay,
    - iv. A private insurance company, and
    - v. A payer source not specified in subsections (C)(20)(f)(i) through (C)(20)(f)(iv);
- 21. The total number of patient care days during the reporting period that the hospice provided hospice services to a patient whose principal diagnosis was related to:
  - a. Cancer,
  - b. Heart disease,
  - c. Dementia,
  - d. Lung disease,
  - e. Kidney disease,
  - f. Stroke or Coma,
  - g. Liver disease,
  - h. HIV-related disease,
  - i. Motorneuron disorder,
  - j. Unspecified debility, and
  - k. Any other disease not specified in subsections (C)(21)(a) through (C)(21)(j);
- 22. If the hospice operates as a hospice inpatient facility:
  - a. The number of FTEs providing hospice services, for each type of employee, during the reporting period; and
  - b. The total number of FTEs providing hospice services during the reporting period;
- 23. If the hospice operates as a hospice service agency:

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- a. The number of FTEs providing hospice services, for each type of employee, during the reporting period; and
  - b. The total number of FTEs providing hospice services during the reporting period;
- 24. The average caseload during the reporting period for a licensed nurse, calculated as the total number of patients assigned to licensed nurses working for the hospice during the reporting period, divided by the total number of licensed nurses working for the hospice during the reporting period;
- 25. The average caseload during the reporting period for a social worker, calculated as the total number of patients assigned to social workers working for the hospice during the reporting period, divided by the total number of social workers working for the hospice during the reporting period;
- 26. The average caseload during the reporting period for nursing personnel other than a licensed nurse, calculated as the total number of patients assigned to nursing personnel other than licensed nurses working for the hospice during the reporting period, divided by the total number of nursing personnel other than licensed nurses working for the hospice during the reporting period;
- 27. The average caseload during the reporting period for a chaplain, calculated as the total number of patients assigned to chaplains working for the hospice during the reporting period, divided by the total number of chaplains working for the hospice during the reporting period;
- 28. The number of individuals who received bereavement services from the hospice during the reporting period;
- 29. The number of individuals from the hospice who provided bereavement services during the reporting period;
- 30. The total number of volunteers during the reporting period;
- 31. The total number of hours that volunteers provided hospice services during the reporting period;
- 32. The number of patient care days during the reporting period, for whom the payer source was:
  - a. Medicare,
  - b. AHCCCS,
  - c. Self-pay,
  - d. A private insurance company, and
  - e. A payer source not specified in subsections (C)(32)(a) through (C)(32)(d);

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- 33. The total number of patient care days specified in subsections (C)(32)(a) through (C)(32)(e);
- 34. The total amount of money billed, during the reporting period to:
  - a. Medicare,
  - b. AHCCCS,
  - c. Self-pay,
  - d. A private insurance company, and
  - e. A payer source not specified in subsections (C)(34)(a) through (C)(34)(d);
- 35. The total amount of money billed during the reporting period;
- 36. The amount of revenue generated, for each type of revenue, by the hospice during the reporting period;
- 37. The amount of allowances given, for each type of allowance, by the hospice during the reporting period;
- 38. The total amount of revenue generated and allowances given by the hospice during the reporting period;
- 39. The operating expenses incurred, for each type of operating expense, by the hospice during the reporting period;
- 40. The total operating expenses incurred by the hospice during the reporting period;
- 41. The difference between the amount identified in subsection (C)(38) and the amount identified in subsection (C)(40);
- 42. The expenses, other than operating expenses, for each type of expense, incurred by the hospice during the reporting period;
- 43. The amount of assets, for each type of asset, of the hospice at the end of the reporting period;
- 44. The total amount of assets of the hospice at the end of the reporting period;
- 45. The amount of liabilities, for each type of liability, of the hospice at the end of the reporting period;
- 46. The total amount of liabilities of the hospice at the end of the reporting period;
- 47. The amount of net assets, for each type of net asset, of the hospice at the end of the reporting period;
- 48. The total amount of net assets of the hospice at the end of the reporting period;
- 49. The difference between the amount identified in subsection (C)(48) and the amount identified in subsection (C)(46); and
- 50. The statement of cash flows required in A.R.S. § 36-125.04(C)(3).

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**D.**     A hospice administrator or designee shall:

1.     Attest, on a form provided by the Department, that, to the best of the knowledge and belief of the hospice administrator or designee, the information submitted according to subsections (B) and (C) is accurate and complete; and
2.     Submit the form specified in subsection (D)(1) as part of the uniform accounting report required in subsection (A).

**E.**     A hospice administrator who receives a request from the Department for revision of a uniform accounting report not prepared according to subsections (B), (C), and (D) shall ensure that the revised uniform accounting report is submitted to the Department:

1.     Within 21 calendar days after the date on the Department's letter requesting an initial revision, and
2.     Within seven calendar days after the date on the Department's letter requesting a second revision.

**F.**     If a hospice administrator or designee does not submit a uniform accounting report according to this Section, the Department may assess civil penalties as specified in A.R.S. § 36-126.